UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

COLCRYS (colchicine)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO (801) 536-0477

CRITERIA FOR GOUT:

- Minimum age requirement: 18 years old.
- Documented failure on allopurinol.
- Documented failure on or a contraindication to corticosteroids and NSAIDS.
- Maximum approved dose is 1.8mg every 3 days.

CRITERIA FOR FAMILIAL MEDITERRANEAN FEVER:

- Minimum age requirement: 4 years old.
- Documented diagnosis of Familial Mediterranean Fever.
- Maximum approved dose is 2.4mg per day.

AUTHORIZATION:

The initial prior authorization will be approved for one year.

RE-AUTHORIZATION:

Telephone call from prescriber's office or pharmacy to (801)538-6155, options 3, 3, 2.

8/26/10

http://health.utah.gov/medicaid/pharmacy